(3) For premiums imposed under paragraph (a)(2) of this section—

(i) For individuals with annual income exceeding 250 percent of the FPL, the agency may require payment of 100 percent of the premiums imposed under this paragraph for a year, such that payment is only required up to 7.5 percent of annual income for individuals whose annual income does not exceed 450 percent of the FPL.

(ii) For individuals whose annual adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986) exceeds $75,000, increased by inflation each calendar year after 2000, the agency must require payment of 100 percent of the premiums for a year, except that the agency may choose to subsidize the premiums using state funds which may not be federally matched by Medicaid.

(4) For any premiums imposed under this section, the agency may waive payment of a premium in any case where the agency determines that requiring the payment will create an undue hardship for the individual or family.

(5) The agency may not apply further consequences or penalties for non-payment other than those listed in this section.

(c) *State plan specifications.* For each premium, enrollment fee, or similar charge imposed under paragraph (a) of this section, subject to the requirements of paragraph (b) of this section, the plan must specify—

(1) The group or groups of individuals that may be subject to the charge;

(2) The amount and frequency of the charge;

(3) The process used by the state to identify which beneficiaries are subject to premiums and to ensure individuals exempt from premiums are not charged; and

(4) The consequences for an individual or family who does not pay.

§ 447.56 Limitations on premiums and cost sharing.

(a) *Exemptions.* (1) The agency may not impose premiums or cost sharing upon the following groups of individuals:

(i) Individuals ages 1 and older and under age 18 eligible under § 435.118 of this chapter.

(ii) Infants under age 1 eligible under § 435.118 of this chapter whose income does not exceed the higher of—

(A) 150 percent FPL (for premiums) or 133 percent FPL (for cost sharing); and

(B) If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act up to 185 percent FPL.

(iii) Individuals under age 18 eligible under §§ 435.120–435.122 or § 435.130 of this chapter.

(iv) Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.

(v) At state option, individuals under age 19, 20 or age 21, eligible under § 435.222 of this chapter.

(vi) Disabled children, except as provided at § 447.55(a)(4) (premiums), who are receiving medical assistance by virtue of the application of the Family Opportunity Act in accordance with sections 1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act.

(vii) Pregnant women, except for premiums allowed under § 447.55(a)(1) and cost sharing for services specified in the state plan as not pregnancy-related, during the pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends.

(viii) Any individual whose medical assistance for services furnished in an institution, or at state option in a home and community-based setting, is reduced by amounts reflecting available income other than required for personal needs.

(ix) An individual receiving hospice care, as defined in section 1905(o) of the Act.

(x) An Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services is exempt from premiums. Indians who are currently receiving or have ever received an item or service furnished by an Indian

health care provider or through referral under contract health services are exempt from all cost sharing.

(xi) Individuals who are receiving Medicaid because of the state's election to extend coverage as authorized by § 435.213 of this chapter (Breast and Cervical Cancer).

(2) The agency may not impose cost sharing for the following services:

(i) Emergency services as defined at section 1932(b)(2) of the Act and § 438.114(a) of this chapter;

(ii) Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the State claims or could claim Federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies;

(iii) Preventive services, at a minimum the services specified at § 457.520 of chapter D, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics; and

(iv) Pregnancy-related services, including those defined at §§ 440.210(a)(2) and 440.250(p) of this chapter, and counseling and drugs for cessation of tobacco use All services provided to pregnant women will be considered as pregnancy-related, except those services specifically identified in the state plan as not being related to the pregnancy.

(v) Provider-preventable services as defined in § 447.26(b).

(b) *Applicability*. Except as permitted under § 447.52(d) (targeted cost sharing), the agency may not exempt additional individuals from cost sharing obligations that apply generally to the population at issue.

(c) *Payments to providers*. (1) Except as provided under paragraphs (c)(2) and (c)(3) of this section, the agency must reduce the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing.

(2) For items and services provided to Indians who are exempt from cost sharing under paragraph (a)(1)(x) of this section, the agency may not reduce the payment it makes to a provider, including an Indian health care provider, by the amount of cost sharing that will otherwise be due from the Indian.

(3) For those providers that the agency reimburses under Medicare reasonable cost reimbursement principles, in accordance with subpart B of this part, an agency may increase its payment to offset uncollected cost sharing charges that are bad debts of providers.

(d) *Payments to managed care organizations*. If the agency contracts with a managed care organization, the agency must calculate its payments to the organization to include cost sharing established under the state plan, for beneficiaries not exempt from cost sharing under paragraph (a) of this section, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

(e) *Payments to states*. No FFP in the state's expenditures for services is available for—

(1) Any premiums or cost sharing amounts that recipients should have paid under §§ 447.52 through 447.55 (except for amounts that the agency pays as bad debts of providers under paragraph (c)(3) of this section; and

(2) Any amounts paid by the agency on behalf of ineligible individuals, whether or not the individual had paid any required premium, except for amounts for premium assistance to obtain coverage for eligible individuals through family coverage that may include ineligible individuals when authorized in the approved state plan.

(f) *Aggregate limits*. (1) Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household may not exceed an aggregate limit of 5 percent of the family's income applied on either a quarterly or monthly basis, as specified by the agency.

(2) If the state adopts premiums or cost sharing rules that could place beneficiaries at risk of reaching the aggregate family limit, the state plan must indicate a process to track each family's incurred premiums and cost sharing through an effective mechanism that does not rely on beneficiary documentation.

(3) The agency must inform beneficiaries and providers of the beneficiaries aggregate limit and notify beneficiaries and providers when a beneficiary has incurred out-of-pocket expenses up to the aggregate family limit and individual family members are no longer subject to cost sharing for the remainder of the family's current monthly or quarterly cap period.

(4) The agency must have a process in place for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium.

(5) Nothing in paragraph (f) shall preclude the agency from establishing additional aggregate limits, including but not limited to a monthly limit on cost sharing charges for a particular service.

§ 447.57 Beneficiary and public notice requirements.

(a) The agency must make available a public schedule describing current premiums and cost sharing requirements containing the following information:

(1) The group or groups of individuals who are subject to premiums and/or cost sharing and the current amounts;

(2) Mechanisms for making payments for required premiums and cost sharing charges;

(3) The consequences for an applicant or recipient who does not pay a premium or cost sharing charge;

(4) A list of hospitals charging cost sharing for non-emergency use of the emergency department; and

(5) A list of preferred drugs or a mechanism to access such a list, including the agency Web site.

(b) The agency must make the public schedule available to the following in a manner that ensures that affected applicants, beneficiaries, and providers are likely to have access to the notice:

(1) Beneficiaries, at the time of their enrollment and reenrollment after a redetermination of eligibility, and when premiums, cost sharing charges, or aggregate limits are revised, notice to beneficiaries must be in accordance with § 435.905(b) of this chapter;

(2) Applicants, at the time of application;

(3) All participating providers; and

(4) The general public.

(c) Prior to submitting to the Centers for Medicare & Medicaid Services for approval a state plan amendment (SPA) to establish or substantially modify existing premiums or cost sharing, or change the consequences for non-payment, the agency must provide the public with advance notice of the SPA, specifying the amount of premiums or cost sharing and who is subject to the charges. The agency must provide a reasonable opportunity to comment on such SPAs. The agency must submit documentation with the SPA to demonstrate that these requirements were met. If premiums or cost sharing is substantially modified during the SPA approval process, the agency must provide additional public notice.

§ 447.88 Options for claiming FFP payment for section 1920A presumptive eligibility medical assistance payments.

(a) The FMAP rate for medical assistance payments made available to a child during a presumptive eligibility period under section 1920A of the Act is the regular FMAP under title XIX, based on the category of medical assistance; that is, the enhanced FMAP is not available for section 1920A presumptive eligibility expenditures.

(b) States have the following 3 options for identifying Medicaid section 1920A presumptive eligibility expenditures and the application of payments for those expenditures:

(1) A State may identify Medicaid section 1920A presumptive eligibility expenditures in the quarter expended with no further adjustment based on the results of a subsequent actual eligibility determination (if any).

(2) A State may identify Medicaid section 1920A presumptive eligibility expenditures in the quarter expended but may adjust reported expenditures based on results of the actual eligibility determination (if any) to reflect the actual eligibility status of the individual, if other than presumptively eligible.